Note: Copies of Form DSL-2470 for reporting deaths under this subsection may be obtained from any Division of Supportive Living regional office. See Appendix C for the addresses and phone numbers of those offices.

HFS 75.04 Prevention service. (1) SERVICE DESCRIPTION. A prevention service makes use of universal, selective and indicated prevention measures described in appendix A. Preventive interventions may be focused on reducing behaviors and actions that increase the risk of abusing substances or being affected by another person's substance abuse.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a prevention service shall comply with all requirements included in s. HFS 75.03 that apply to a prevention service, as shown in Table 75.03, and, in addition, a prevention service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) REQUIRED PERSONNEL. (a) A professional employed by the service shall be knowledgeable and skilled in all areas of substance abuse prevention as defined under the certified prevention professional competencies established by the Wisconsin certification board, inc., or documentation of similar prevention competencies approved by the department.

(b) Paraprofessional personnel shall be knowledgeable and skilled in the areas of substance abuse prevention as defined under the registered prevention specialist competencies established by the Wisconsin certification board, inc., or documentation of similar prevention competencies approved by the department.

(c) Staff without previous experience in substance abuse prevention shall receive inservice training and shall be supervised in performing work activities identified in sub. (4) by a professional qualified under par. (a).

(4) OPERATION OF THE PREVENTION SERVICE. (a) *Strategies.* A prevention service shall utilize all of the following strategies in seeking to prevent substance abuse and its effects:

1. Information dissemination. This strategy aims at providing awareness and knowledge of the nature and extent of the identified problem and providing knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience. Examples of activities that may be conducted and methods used in carrying out this strategy include the following:

a. Operation of an information clearinghouse.

b. Development and distribution of a resource directory.

c. Media campaigns.

d. Development and distribution of brochures.

e. Radio and TV public service announcements.

f. Speaking engagements.

g. Participation in health fairs and other health promotion activities.

2. Education. This strategy involves two-way communication and is distinguished from the information dissemination strategy by interaction between the educator or facilitator and the participants. Activities under this strategy are directed at affecting critical life and social skills, including decision-making, refusal skills, critical analysis, for instance, of media messages, and systematic judgment abilities. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

a. Classroom or small group sessions.

b. Parenting and family management classes.

c. Peer leader or helper programs.

d. Education programs for youth groups.

e. Children of substance abuser groups.

3. Promotion of healthy activities. This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use or promote activities that lend themselves to the building of resiliency among youth and families. The assumption is that constructive and healthy activities offset the attraction to or otherwise meet the needs that may be fulfilled by alcohol, tobacco and other drugs. Alternative activities also provide a means of character-building and may promote healthy relationships between youth and adults in that participants may internalize the values and attitudes of the individuals involved in establishing the prevention services objectives. Examples of healthy activities that may be promoted or conducted under this strategy may include the following:

a. Drug-free dances and parties.

b. Youth or adult leadership activities.

c. After-school activities such as participation in athletic activities, in music lessons, an art club or the school newspaper.

d. Community drop-in centers.

e. Community service activities.

4. Problem identification and referral. This strategy is to identify individuals who have demonstrated at-risk behavior, such as indulging in illegal or age-inappropriate use of tobacco or alcohol or indulging in the first use of illicit drugs, to determine if their behavior can be reversed through education. This strategy does not include activities designed to determine if a person is in need of treatment. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

a. Employe assistance programs.

b. Student assistance programs.

c. Educational programs for individuals charged with driving while under the influence or driving while intoxicated.

5. Environmental. This strategy aims at establishing written or unwritten community standards, codes and attitudes, thereby influencing the incidence and prevalence of at-risk behavior in the general population. This strategy distinguishes between activities that center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

a. Promoting the establishment and review of policies for schools related to the use of alcohol, tobacco and drugs.

b. Providing technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use.

c. Modifying alcohol and tobacco advertising practices.

d. Supporting local enforcement procedures to limit violent behavior.

e. Establishing policies that create opportunities for youth to become involved in their communities.

6. Community-based process. This strategy seeks to enhance the ability of the community to more effectively provide prevention, remediation and treatment services for behaviors that lead to intensive services. Activities under this strategy include organizing, planning, enhancing the efficiency and effectiveness of services implementation, interagency collaboration, coalition building and networking. Examples of activities that may be conducted and methods used in carrying out this strategy are the following:

a. Community and volunteer training, such as neighborhood action training and training of key people in the system.

b. Systematic planning in the above areas.

c. Multi-agency coordination and collaboration.

d. Facilitating access to services and funding.

e. Community team-building.

(b) *Goals and objectives.* A prevention service shall have written operational goals and objectives and shall specify in writing the methods by which they will be achieved and the target populations.

(c) *Documentation of coordination.* A prevention service shall provide written documentation of coordination with other human service agencies, organizations or services that share similar goals.

(d) *Records.* A prevention service shall maintain records on the number of individuals served by implementation of each prevention strategy and retain records as necessary for meeting certification and funding requirements.

(5) PREVENTION SERVICE EVALUATION. (a) A prevention service shall have an evaluation process that measures the outcomes of the services provided.

(b) A prevention service shall evaluate the views of consumers about the service as they are provided and shall adjust goals and objectives accordingly.

(c) A prevention service shall have a written policy and a defined process to provide individuals with the opportunity to express opinions regarding ongoing services, staff and the methods by which individual prevention activities are offered.

HFS 75.05 Emergency outpatient service. (1) SERVICE DESCRIPTION. An emergency outpatient service operates an emergency phone service and provides on-site crisis intervention to deal with all outpatient emergencies related to substance abuse, including socio-emotional crises, attempted suicide and family crises; provides the examination required under s. 51.45 (11) (c), Stats.; and, if needed, provides or arranges for transportation of a patient to the emergency room of a general hospital for medical treatment.

(2) REQUIREMENTS. To receive certification from the department under this chapter, an emergency outpatient service shall comply with all requirements included in s. HFS 75.03 that apply to an emergency outpatient service, as shown in Table 75.03, and, in addition, an emergency outpatient service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) REQUIRED PERSONNEL. (a) An emergency outpatient service shall have staff available who are capable of providing coverage for an emergency phone service and for providing on-site crisis intervention.

(b) A service shall have a written plan for staffing the service and shall document that all of the following have been taken into consideration:

1. The nature of previously observed and anticipated emergencies and the probability of emergencies as related to geographical, seasonal, temporal and demographic factors.

2. The adequacy of the emergency communication system used by the service when consultation is required.

3. The types of emergency services to be provided.

4. The skills of staff members in providing emergency services.

5. Difficulty in contacting staff members.

6. The estimated travel time for a staff member to arrive at an emergency care facility or at the location of an emergency.

(4) SERVICE OPERATIONS. (a) An emergency outpatient service shall provide emergency telephone coverage 24 hours per day and 7 days a week, as follows:

1. The telephone number of the program shall be well-publicized.

2. A log shall be kept of all emergency calls as well as of calls requesting treatment information. For each call, the log shall describe all of the following:

a. The purpose of the call.

b. Caller identification information, if available.

c. Time and date of call.

d. Recommendations made.

e. Other action taken.

(b) A service shall have written procedures that ensure prompt evaluation of both the physiological and psychological status of the individual so that rapid determination can be made of the nature and urgency of the problem and of the type of treatment required.

(c) A service shall have written procedures for dealing with anticipated medical and psychiatric complications of substance abuse emergencies.

(d) A service shall either be able to provide medical support for substance abuse-related emergencies on-site or have the capability of transporting the individual to a local hospital or other recognized medical facility.

(e) If the emergency outpatient service is not a part of a general hospital, the service shall enter into a formal agreement with a local hospital for the hospital to receive referrals from the service on a 24-hour basis and provide services with the same standards of care prevailing for emergency cases treated in the hospital that are not related to substance abuse.

HFS 75.06 Medically managed inpatient detoxification service. (1) SERVICE DESCRIPTION. A medically managed inpatient detoxification service provides 24-hour per day observation and monitoring of patients in a hospital setting, with round-the-clock nursing care, physician management and availability of all other resources of the hospital.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a medically managed inpatient detoxification service shall comply with all requirements included in s. HFS 75.03 that apply to a medically managed inpatient detoxification service, as shown in Table 75.03, and, in addition, a medically managed detoxification service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) REQUIRED PERSONNEL. (a) A medically managed inpatient detoxification service shall have a staffing pattern that is consistent with s. HFS 124.13 requirements.

(b) The service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

(4) SERVICE OPERATIONS. (a) A medically managed inpatient detoxification service shall have written agreements with certified substance abuse service providers or systems to provide rehabilitative substance abuse care if determined necessary by substance abuse screening and the application of approved patient placement criteria administered by the service.

(b) A service shall have written policies and procedures for the management of belligerent and disturbed patients, which shall include transfer of patients to another appropriate facility if necessary.

(c) A service shall develop with each patient a detoxification plan and a discharge plan for the patient that addresses the patient's follow-up service needs determined by application of approved patient placement criteria, and the provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

HFS 75.07 Medically monitored residential detoxification service. (1) SERVICE DESCRIPTION. A medically monitored residential detoxification service is a 24-hour per day service in a residential setting providing detoxification service and monitoring. Care is provided by a multi-disciplinary team of service personnel, including 24-hour nursing care under the supervision of a physician. Included is the provision of an examination in accordance with s. 51.45 (11) (c), Stats., and transportation, if needed, to an emergency room of a general hospital for medical treatment.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a medically monitored residential detoxification service shall comply with all requirements included in s. HFS 75.03 that apply to a medically monitored detoxification service, as shown in Table 75.03, and, in addition, a medically monitored residential detoxification service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) ORGANIZATIONAL REQUIREMENTS. Before operating or expanding a medically monitored residential detoxification service, a facility shall be approved under ch. HFS 124 as a hospital or licensed under ch. HFS 83 as a community-based residential facility.

(4) REQUIRED PERSONNEL. (a) A medically monitored residential detoxification service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

(b) The service shall have a nursing director who is a registered nurse.

(c) A registered nurse shall be available on site on a 24-hour basis.

(d) A physician shall be available on site on a 24-hour basis.

(5) SERVICE OPERATIONS. (a) A physician shall review and document the medical status of a patient within 72 hours after admission.

(b) A service shall have written policies and procedures for the management of belligerent and disturbed patients, which shall include transfer of a patient to another appropriate facility if necessary.

(c) A service shall have a written agreement with certified substance abuse service providers or systems to provide care after the patient is discharged from the service.

(d) A service shall have a written agreement with a hospital for the hospital to provide emergency medical services for patients and shall provide escort and transportation to the hospital. If necessary, the service shall also provide escort and transportation for return to the service.

(e) The service shall develop with each patient a detoxification plan and a discharge plan for the patient that addresses the patient's follow-up service needs, determined from the application of approved patient placement criteria administered by the service, and shall include provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

(f) A service shall have a treatment room that has in it at least the following:

1. First aid supplies maintained and readily available to all personnel responsible for the care of patients.

2. Separate locked cabinets exclusively for all pharmaceutical supplies.

HFS 75.08 Ambulatory detoxification service. (1) SERVICE DESCRIPTION. An ambulatory detoxification service is a medically managed or monitored structured detoxification service on an outpatient basis, delivered by a physician or other service personnel acting under the supervision of a physician.

(2) REQUIREMENTS. To receive certification from the department under this chapter, an ambulatory detoxification service shall comply with all requirements included in s. HFS 75.03 that apply to an ambulatory detoxification service, as shown in Table 75.03, and, in addition, an ambulatory detoxification service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) REQUIRED PERSONNEL. (a) An ambulatory detoxification service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

(b) The service shall have a nursing director who is a registered nurse.

(c) A registered nurse shall be available on a 24-hour basis.

(d) A physician shall be available on a 24-hour basis.

(4) SERVICE OPERATIONS. (a) An ambulatory detoxification service shall provide patients with 24-hour access to medical personnel and a substance abuse counselor.

(b) The service shall have written agreements with certified substance abuse service providers or systems to provide care after the patient is discharged from the service.

(c) A physician shall document review of admission data within 24 hours after a person's admission.

(d) The service shall have a written agreement with a hospital for the hospital to provide emergency medical services for patients and shall provide escort and transportation to the hospital. If necessary, the service shall also provide escort and transportation for return to the service.

(e) The service shall have a treatment room, which has in it at least the following:

1. First aid supplies maintained and readily available to all personnel responsible for the care of patients.

2. Separate locked cabinets exclusively for all pharmaceutical supplies.

(f) The service shall have written policies and procedures for the management of belligerent and disturbed patients, which shall include transfer of a patient to another appropriate facility if necessary.

(g) The service shall develop a detoxification plan and a discharge plan for each patient that addresses the patient's follow-up service needs determined by application of approved patient placement criteria administered by the service, and the provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

HFS 75.09 Residential intoxication monitoring service. (1) SERVICE DESCRIPTION. A residential intoxication monitoring service provides 24-hour per day observation by staff to monitor the safe resolution of alcohol or sedative intoxication and to monitor for the development of alcohol withdrawal for intoxicated patients who are not in need of emergency medical or psychological care. The service is provided in a supportive setting that includes provision of nourishment and emotional support.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a residential intoxication monitoring service shall comply with all requirements included in s. HFS 75.03 that apply to a residential intoxication monitoring service, as shown in Table 75.03, and, in addition, a residential intoxication monitoring service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) ORGANIZATIONAL REQUIREMENTS. Before operating or expanding a residential intoxication monitoring service, a facility shall be approved under ch. HFS 124 as a hospital, licensed under ch. HFS 83 as a community-based residential facility, certified under ch. HFS 82 or licensed under ch. HFS 88 as an adult family home.

(4) REQUIRED PERSONNEL. (a) A service shall have at least one staff person trained in the recognition of withdrawal symptoms on duty 24 hours per day, 7 days per week.

(b) A service shall ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.

(5) SERVICE OPERATIONS. (a) *Screening.* A patient shall be screened by medical personnel before admission to the service, unless the service has documentation of the patient's current physical condition.

(b) *Prohibited admissions.* No person may be admitted if any of the following apply:

1. His or her behavior is determined by the service to be dangerous to self or others.

2. He or she requires professional nursing or medical care.

3. He or she is incapacitated by alcohol and is placed in or is determined to be in need of protective custody by a law enforcement officer as required under s. 51.45 (11) (b), Stats.

4. He or she is under the influence of any substance other than alcohol or a sedative.

5. He or she requires restraints.

6. He or she requires medication normally used for the detoxification process.

(c) *Observation.* Trained staff shall observe a patient and record the patient's condition at intervals no greater than every 30 minutes during the first 12 hours following admission.

(d) *Emergency medical treatment.* A service shall have a written agreement with a general hospital for the hospital to provide emergency medical treatment of patients. Escort and transportation shall be provided as necessary to a patient who requires emergency medical treatment.

(e) *Medications.* 1. A service shall not administer or dispense medications.

2. When a patient has been admitted with prescribed medication, staff shall consult with the patient's physician or other person licensed to prescribe and administer medications to determine the appropriateness of the patient's continued use of the medication while under the influence of alcohol or sedatives.

3. If approval for continued use of prescribed medication is received from a physician, the patient may self-administer the medication under the observation of service staff.

(f) *Discharge plan.* A service shall develop with each patient a discharge plan for the patient which shall address the patient's follow-up service needs determined by application of approved patient placement criteria administered by the service, and the provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.

HFS 75.10 Medically managed inpatient treatment service. (1) SERVICE DESCRIPTION. A medically managed inpatient treatment service is operated by a general or specialty hospital, and includes 24-hour nursing care, physician management and the availability of all other resources of the hospital.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a medically managed inpatient treatment service shall comply with all requirements included in s. HFS 75.03 that apply to a medically managed inpatient treatment service, as shown in Table 75.03, and, in addition, a medically managed inpatient treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) ORGANIZATIONAL REQUIREMENTS. Before operating or expanding an inpatient treatment service, a facility shall do all of the following:

(a) Submit for approval to the department, a written justification for the service, documenting if the service has been operating, the service's effectiveness and the need for additional inpatient treatment resources in the geographic area in which the service will operate or is operating.

(b) Notify the county department of community programs under s. 51.42, Stats., in the area in which the service will operate or is operating of the intention to begin to operate or expand the service.

(c) Be approved as a hospital under ch. HFS 124.

(4) REQUIRED PERSONNEL. (a) An inpatient treatment service shall have all of the following personnel:

1. A director who is responsible for the overall operation of the service, including the therapeutic design and delivery of services.

2. A medical director.

3. A consulting psychiatrist who is licensed under ch. 448, Stats., and board-certified or eligible for certification by the American board of psychiatry and neurology or a consulting clinical psychologist licensed under ch. 455, Stats., who will be available as needed, with a written agreement to that effect. Each consultant shall be sufficiently knowledgeable about substance abuse and dependence treatment to carry out his or her assigned duties.

4. A mental health professional who is available either as an employe of the service or through written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

5. At least one full-time certified substance abuse counselor for every 10 patients or fraction thereof.

6. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff, or a person outside the agency who is a clinical supervisor and who by written agreement will provide ongoing clinical supervision of the counseling staff.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated to be responsible for the operation of the service shall be on the premises at all times. That person may provide direct counseling or other duties in addition to being in charge of the service.

(d) Other persons, such as volunteers and students, may work in an inpatient treatment facility if all of the following conditions are met:

1. Volunteers and students do not replace direct care staff required under par. (a) or carry out the duties of direct care staff, and there are written descriptions of their responsibilities and duties.

2. Volunteers and students are supervised by professional staff.

3. The inpatient treatment service has written procedures for selecting, orienting and providing in-service training to volunteers.

4. Volunteers and students meet the sensitivity and training expectations under s. HFS 75.03 (3) (h).

(5) CLINICAL SUPERVISION. A medically managed inpatient treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as follows:

(a) A clinical supervisor shall provide a certified substance abuse counselor with not less than 30 minutes of clinical supervision for every 40 hours of counseling rendered.

(b) A clinical supervisor shall provide a non-certified or registered substance abuse counselor who has a certification plan on file with the Wisconsin certification board, inc., and any other treatment staff member, except a physician or licensed clinical psychologist, with not less than one hour of direct service review for every 40 hours of counseling or other treatment rendered.

(c) A clinical supervisor shall provide supervision to substance abuse counselors in the core functions identified in the certification standards of the Wisconsin certification board, inc., and shall exercise supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility.

(6) SERVICE OPERATIONS. (a) A physician, registered nurse or physician assistant shall conduct medical screening of a patient no later than 24 hours after the person's admission to a service to identify health problems and to screen for communicable diseases.

(b) A service shall arrange for services for a patient with medical needs unless otherwise arranged for by the patient.

(c) A service shall complete intake within 24 hours of a person's admission to the service except that the initial assessment and treatment plan shall be completed within 4 days of admission.

(d) A service shall arrange for additional psychological tests for a patient as needed.

(e) A service shall have a written statement describing its treatment philosophy and objectives in providing care and treatment for substance abuse problems.

(f) A substance abuse counselor or other qualified staff member of a service shall provide a minimum of 12 hours of counseling per week for each patient, including individual and group counseling. Family and couples counseling shall be provided or made available, when appropriate. The service shall ensure that:

1. Each patient receives at least one hour of individual counseling per week.

2. The service's treatment schedule is communicated to patients in writing and by any other means necessary for patients with communication difficulties.

(g) Services required by a patient but not provided by a service shall be provided by other appropriate hospital services or outside agencies.

(h) A service staff member shall be trained in life-sustaining techniques and emergency first aid.

(i) A service shall have a written policy on urinalysis that shall include both the following:

1. Procedures for collection and analysis of samples.

2. A description of how urinalysis reports are used in the treatment of a patient.

(7) ADMISSION. (a) Admission to an inpatient treatment service shall be by order of a physician. The physician's referral shall be in writing or indicated by the physician's signature on the placement criteria summary.

(b) Admission to an inpatient treatment service is appropriate only if one of the following conditions is met:

1. The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

2. The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria.

HFS 75.11 Medically monitored treatment service. (1) SERVICE DESCRIPTION. A medically monitored treatment service operates as a 24-hour, community-based service providing observation, monitoring and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week for each patient.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a medically monitored treatment service shall comply with all requirements included in s. HFS 75.03 that apply to a medically monitored treatment service as shown in Table 75.03 and, in addition, shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) ORGANIZATIONAL REQUIREMENTS. Before operating or expanding a medically monitored treatment service, a facility shall be approved under ch. HFS 124 as a hospital or shall be licensed under ch. HFS 83 as a community-based residential facility.

(4) REQUIRED PERSONNEL. (a) A medically monitored treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.

2. At least one full-time substance abuse counselor for every 15 patients or fraction thereof enrolled in the service.

3. A physician available to provide medical supervision and clinical consultation as either an employe of the service or through a written agreement.

4. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff or a person outside the agency who is a clinical supervisor and who by written agreement will provide ongoing clinical supervision of the counseling staff.

5. A mental health professional available either as an employe of the service or through written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated by the director to be responsible for the operation of the service shall be on the premises at all times the service is in operation. That person may provide direct counseling or other duties in addition to being in charge of the service.

(5) CLINICAL SUPERVISION. A medically monitored treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as follows:

(a) The clinical supervisor shall provide a certified substance abuse counselor with not less than 30 minutes of clinical supervision for every 40 hours of counseling rendered.

(b) The clinical supervisor shall provide a non-certified or registered substance abuse counselor who has a certification plan on file with the Wisconsin certification board, inc., and any other treatment staff member, except a physician or licensed clinical psychologist, with not less than one hour of direct service review for every 40 hours of counseling or other treatment rendered.

(c) The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the core functions identified in the certification standards of the Wisconsin certification board, inc., and shall exercise supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility.

(6) SERVICE OPERATIONS. (a) 1. A physician, registered nurse or physician assistant shall conduct a medical screening of a patient no later than 7 working days after the person's admission to a service to identify health problems and screen for communicable diseases unless there is documentation that screening was completed within 90 days prior to admission.

2. A service shall arrange for services for a patient with medical needs unless otherwise arranged by the patient.

(b) A service shall complete intake within 24 hours of a person's admission to the service except that the assessment and treatment plan shall be completed within 4 days of admission.

(c) A service shall arrange for additional psychological tests for a patient as needed.

(d) A service shall operate 24 hours per day, 7 days per week.

(e) Each service shall have a written statement describing its treatment philosophy and objectives in providing care and treatment for substance abuse problems.

(f) A service shall provide a minimum of 12 hours per week of treatment for each patient, including individual and group counseling. Family and couples counseling shall be provided or made available, when appropriate. The service shall ensure that:

1. Each patient receives at least one hour of individual counseling per week.

2. The service's treatment schedule is communicated to patients in writing and by any other means necessary for patients with communication difficulties.

(g) A service shall ensure that 3 meals per day are provided to each patient.

(h) A service shall ensure that services required by a patient that are not provided by the service are provided to the patient by referral to an appropriate agency.

(i) A service shall have a written agreement with a hospital for provision of emergency and inpatient medical services, when needed.

(j) A service staff member shall be trained in life-sustaining techniques and emergency first aid.

(k) A service shall have a written policy on urinalysis that includes all of the following:

1. Procedures for collection and analysis of samples.

2. A description of how urinalysis reports are used in the treatment of the patient.

(7) ADMISSION. Admission to a medically monitored treatment service is appropriate only if one of the following conditions is met:

(a) The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

(b) The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria.

HFS 75.12 Day treatment service. (1) SERVICE DESCRIPTION. A day treatment service is a medically monitored, and non-residential substance abuse treatment service which consists of regularly scheduled sessions of various modalities, such as individual and group counseling and case management, provided under the supervision of a physician. Services are provided in a scheduled number of sessions per day and week, with each patient receiving a minimum of 12 hours of counseling per week.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a day treatment service shall comply with all requirements included in s. HFS 75.03 that apply to a day treatment service, as shown in Table 75.03, and, in addition, a day treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) ORGANIZATIONAL REQUIREMENTS. A day treatment service may be a stand-alone service or may be co-located in a facility that includes other services.

(4) REQUIRED PERSONNEL. (a) A day treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.

2. At least one full-time substance abuse counselor for every 15 patients or fraction thereof enrolled in the service.

3. A physician available to provide medical consultation and clinical consultation as either an employe of the service or through a written agreement.

4. A mental health professional available either as an employe of the service or through a written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

5. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff or a person outside the agency who is a clinical supervisor and who by written agreement will provide ongoing clinical supervision of the counseling staff.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated by the director to be responsible for the operation of the service shall be on the premises at all times the service is in operation. That person may provide direct counseling or other duties in addition to being in charge of the service.

(5) CLINICAL SUPERVISION. (a) A day treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as follows:

1. The clinical supervisor shall provide a certified substance abuse counselor with not less than 30 minutes of clinical supervision for every 40 hours of counseling rendered.

2. The clinical supervisor, shall provide a non-certified or registered substance abuse counselor who has a certification plan on file with the Wisconsin certification board, inc., and any other treatment staff member, except a physician or licensed clinical psychologist, with not less than one hour of clinical supervision for every 40 hours of counseling rendered.

(b) The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the core functions identified in the certification standards of the Wisconsin certification board, inc., and shall exercise supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility.

(6) SERVICE OPERATIONS. (a) A service shall work with patients who need health care services but do not have access to them to help them gain access to those services.

(b) A service shall complete a patient's treatment plan within 2 visits after admission.

(c) A service shall arrange for additional psychological tests for a patient as needed.

(d) Each service shall have a written statement describing its treatment philosophy and objectives in providing care and treatment for substance abuse problems.

(e) A substance abuse counselor shall provide a minimum of 12 hours of counseling per week for each patient, including individual and group counseling. Family and couples counseling shall be provided or made available, when appropriate. The service shall ensure that:

1. Each patient receives at least one hour of individual counseling per week.

2. The service's treatment schedule is communicated to patients in writing and by any other means necessary for patients with communication difficulties.

3. The maximum amount of time between counseling sessions does not exceed 72 hours in any consecutive 7-day period.

(f) A service shall provide services at times that allow the majority of the patient population to maintain employment or attend school.

(g) A service patient may not simultaneously be an active patient in a medically managed inpatient treatment service, a medically monitored treatment service or an outpatient treatment service.

(h) Services required by a patient that are not provided by the service shall be provided by referral to an appropriate agency.

(i) A service shall have a written agreement with a hospital for provision of emergency and inpatient medical services when needed.

(j) A service staff member shall be trained in life-sustaining techniques and emergency first aid.

(k) A service shall have a written policy on urinalysis that includes all of the following:

1. Procedures for collection and analysis of samples.

2. A description of how urinalysis reports are used in the treatment of the patient.

(7) ADMISSION. Admission to a day treatment service is appropriate only if one of the following conditions is met:

(a) The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

(b) The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria.

HFS 75.13 Outpatient treatment service. (1) SERVICE DESCRIPTION. An outpatient treatment service is a non-residential treatment service totaling less than 12 hours of counseling per patient per week, which provides a variety of evaluation, diagnostic, crisis and treatment services relating to substance abuse to ameliorate negative symptoms and restore effective functioning. Services include individual counseling and intervention and may include group therapy and referral to non-substance abuse services that may occur over an extended period.

(2) REQUIREMENTS. To receive certification from the department under this chapter, an outpatient treatment service shall comply with all requirements included in s. HFS 75.03 that apply to an outpatient treatment service, as shown in Table 75.03, and, in addition, an outpatient treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) REQUIRED PERSONNEL. (a) An outpatient treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.

2. A physician available to provide medical supervision and clinical consultation as either an employe of the service or through a written agreement.

3. A substance abuse counselor available during hours of operation.

4. A mental health professional available either as an employe of the service or through a written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

5. A clinical supervisor to provide ongoing clinical supervision of the counseling staff, or a person outside the agency who is a clinical supervisor and who by a written agreement will provide ongoing clinical supervision of the counseling staff.

(b) A clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(c) A trained staff member designated by the director to be responsible for the operation of the service shall be on the premises at all times the service is in operation. That person may provide direct counseling or other duties in addition to being in charge of the service.

(4) CLINICAL SUPERVISION. (a) An outpatient treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as follows:

1. A clinical supervisor shall provide a certified substance abuse counselor with not less than 30 minutes of clinical supervision for every 40 hours of counseling rendered.

2. A clinical supervisor shall provide a non-certified or registered substance abuse counselor who has a certification plan on file with the Wisconsin certification board, inc., and any other treatment staff member, except a physician or a licensed clinical psychologist, with not less than one hour of clinical supervision for every 40 hours of counseling rendered.

(b) A clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the core functions identified in the certification standards of the Wisconsin certification board, inc., and shall exercise supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility.

(5) SERVICE OPERATIONS. (a) A service shall work with patients who need health care services but do not have access to them to help them gain access to those services.

(b) A service shall complete a patient's treatment plan within two visits after admission.

(c) A service shall arrange for additional psychological tests for a patient as needed.

(d) Service staff shall review, evaluate and revise a patient's treatment plan, as needed, in consultation with the clinical supervisor, based on ongoing assessment of the patient. If a patient is dually diagnosed, service staff shall review, evaluate and revise the patient's treatment plan, as needed, in consultation also with a mental health professional.

(e) The service medical director or licensed clinical psychologist shall establish the patient's diagnosis or review and concur with the diagnosis made by the patient's primary physician, and shall review the recommended level of care needed, the assessment report and the treatment plan. The medical director or licensed clinical psychologist shall sign and date a statement that these tasks have been carried out and shall insert the statement in the patient's case record.

(6) ADMISSION. Admission to an outpatient treatment service is appropriate only if one of the following conditions is met:

(a) The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

(b) The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria.

HFS 75.14 Transitional residential treatment service. (1) SERVICE DESCRIPTION. A transitional residential treatment service is a clinically supervised, peer-supported therapeutic environment with clinical involvement. The service provides substance abuse treatment in the form of counseling for 3 to 11 hours per patient weekly, immediate access to peer support through the environment and intensive case management which may include direct education and monitoring in the areas of personal health and hygiene, community socialization, job readiness, problem resolution counseling, housekeeping and financial planning.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a transitional residential treatment service shall comply with all requirements included in s. HFS 75.03 that apply to a transitional residential treatment service, as shown in Table 75.03, and, in addition, a transitional residential treatment service shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) ORGANIZATIONAL REQUIREMENTS. Before operating or expanding a transitional residential treatment service, a facility shall be approved under ch. HFS 124 as a hospital, licensed under ch. HFS 83 as a community-based residential facility, certified under ch. HFS 82 or licensed under ch. HFS 88 as an adult family home.

(4) REQUIRED PERSONNEL. (a) A transitional residential treatment service shall have the following personnel:

1. A director responsible for the overall operation of the service, including the therapeutic design and delivery of services.

2. A physician available to provide medical supervision and clinical consultation as either an employe of the service or under a written contract with the service.

3. At least one full-time substance abuse counselor for every 15 patients or fraction thereof.

4. At least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff, or a person outside the agency who is a clinical supervisor and who by a written agreement will provide ongoing clinical supervision of the counseling staff.

5. A mental health professional available either as an employe of the service or through written agreement to provide joint and concurrent services for the treatment of dually diagnosed patients.

(b) A certified clinical supervisor who meets the requirements of a substance abuse counselor may provide direct counseling services in addition to his or her supervisory responsibilities.

(5) CLINICAL SUPERVISION. (a) A transitional residential treatment service shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as follows:

1. The clinical supervisor shall provide a certified substance abuse counselor with not less than 30 minutes of direct service review for every 40 hours of counseling rendered.

2. A clinical supervisor shall provide a non-certified or registered substance abuse counselor who has a certification plan on file with the Wisconsin certification board, inc., and any other treatment staff member, except a physician or a licensed clinical psychologist, with not less than one hour of direct service review for every 40 hours of counseling rendered.

(b) The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the core functions identified in the certification standards of the Wisconsin certification board, inc, and shall exercise supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility.

(6) SERVICE OPERATIONS. (a) *Medical screening.* 1. A physician, registered nurse or physician assistant shall conduct medical screening of a patient no later than 7 working days after the person's admission to identify health problems and to screen for communicable diseases unless there is documentation that screening was completed within 90 days prior to admission.

2. A patient continuing in treatment shall receive an annual follow-up medical screening unless the patient is being seen regularly by a personal physician.

(b) *Medical service needs.* A service shall arrange for services for a patient with medical needs unless otherwise arranged for by the patient.

(c) *Intake.* A service shall complete intake within 24 hours of a person's admission to the service except that the initial assessment and initial treatment plan shall be completed within 4 working days of admission.

(d) *Hours of operation.* A service shall operate 24 hours per day and 7 days per week.

(e) *Policies and procedures manual.* A service shall have a written policy and procedures manual that includes all of the following:

1. The service philosophy and objectives.

2. The service's patient capacity.

3. A statement concerning the type and physical condition of patients appropriate for the service.

4. Admission policy, including:

a. Target group served, if any.

b. Limitations on admission.

5. Procedures for screening for communicable disease.

6. Service goals and services defined and justified in terms of patient needs, including:

a. Staff assignments to accomplish service goals.

b. Description of community resources available to assist in meeting the service's treatment goals.

(f) *Documentation of review.* 1. A service shall maintain documentation that the governing body, director and representatives of the administrative and direct service staffs have annually revised, updated as necessary and approved the policy and procedures manual, including the service philosophy and objectives.

2. The service shall maintain documentation to verify that each staff member has reviewed a copy of the policy and procedures manual.

(g) *Emergency medical care.* A service shall have a written agreement with a hospital or clinic for the hospital or clinic to provide emergency medical care to patients.

(h) *Emergency transportation.* A service shall have arrangements for emergency transportation, when needed, of patients to emergency medical care services.

(i) *Treatment plan.* The service's treatment staff shall prepare a written treatment plan for each patient referred from prior treatment service, which is designed to establish continuing contact for the support of the patient. A patient's treatment plan shall include information, unmet goals and objectives from the patient's prior treatment experience and treatment staff shall review and update the treatment plan every 30 days.

(j) *Support services.* A service shall provide support services that promote self-care by the patient, which shall include all of the following:

1. Planned activities of daily living.

2. Planned development of social skills to promote personal adjustment to society upon discharge.

(k) *Employment related services.* A service shall make job readiness counseling, problem-resolution counseling and prevocational and vocational training activities available to patients.

(L) *Recreational services.* A service shall have planned recreational services for patients, which shall include all of the following:

1. Emphasis on recreation skills in independent living situations.

2. Use of both internal and community recreational resources.

(7) ADMISSION. Admission to a transitional residential treatment service is appropriate only for one of the following reasons:

(a) The person was admitted to and discharged from one or more services under s. HFS 75.10, 75.11, 75.12 or 75.13 within the past 12 months or is currently being served under either s. HFS 75.12 or 75.13.

(b) The person has an extensive lifetime treatment history and has experienced at least two detoxification episodes during the past 12 months, and one of the following conditions is met:

1. The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria.

2. The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria.

HFS 75.15 Narcotic treatment service for opiate addiction. (1) SERVICE DESCRIPTION. A narcotic treatment service for opiate addiction provides for the management and rehabilitation of selected narcotic addicts through the use of methadone or other FDA-approved narcotics and a broad range of medical and psychological services, substance abuse counseling and social services. Methadone and other FDA-approved narcotics are used to prevent the onset of withdrawal symptoms for 24 hours or more, reduce or eliminate drug hunger or craving and block the euphoric effects of any illicitly self-administered narcotics while the patient is undergoing rehabilitation.

(2) REQUIREMENTS. To receive certification from the department under this chapter, a narcotic treatment service for opiate addiction shall comply with all requirements included in s. HFS 75.03 and all requirements included in s. HFS 75.13 that apply to a narcotic treatment service for opiate addiction, as shown in Table 75.03, and, in addition, a narcotic treatment service for opiate addiction shall comply with the requirements of this section. If a requirement in this section conflicts with an applicable requirement in s. HFS 75.03, the requirement in this section shall be followed.

(3) DEFINITIONS. In this section:

(a) "Biochemical monitoring" means the collection and analysis of specimens of body fluids, such as blood or urine, to determine use of licit or illicit drugs.

(b) "Central registry" means an organization that obtains from 2 or more methadone programs patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of preventing an individual's concurrent enrollment in more than one program.

(c) "Clinical probation" means the period of time determined by the treatment team that a patient is required to increase frequency of service attendance.

(d) "Initial dosing" means the first administration of methadone or other FDA-approved narcotic to relieve a degree of withdrawal and drug craving of the patient.

(e) "Mandatory schedule" means the required dosing schedule for a patient and the established frequency that the patient must attend the service.

(f) "Medication unit" means a facility established as part of a service but geographically separate from the service, from which licensed private practitioners and community pharmacists are:

1. Permitted to administer and dispense a narcotic drug.

2. Authorized to conduct biochemical monitoring for narcotic drugs.

(g) "Objectively intoxicated person" means a person who is determined through a breathalyzer test to be under the influence of alcohol.

(h) "Opioid addiction" means psychological and physiological dependence on an opiate substance, either natural or synthetic, that is beyond voluntary control.

(i) "Patient identifying information" means the name, address, social security number, photograph or similar information by which the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information.

(j) "Phase" means a patient's level of dosing frequency.

(k) "Service physician" means a physician licensed to practice medicine in the jurisdiction in which the program is located, who assumes responsibility for the administration of all medical services performed by the narcotic treatment service including ensuring that the service is in compliance with all federal, state and local laws relating to medical treatment of narcotic addiction with a narcotic drug.

(L) "Service sponsor" means a person or a representative of an organization who is responsible for the operation of a narcotic treatment service and for all service employes including any practitioners, agents or other persons providing services at the service or at a medication unit.

(m) "Take-homes" means medications such as methadone that reduce the frequency of a patient's service visits and with the approval of the service physician, are dispensed in an oral form and are in a container that discloses the treatment service name, address and telephone number and the patient's name, the dosage amount and the date on which the medication is to be ingested.

(n) "Treatment contracting" means an agreement developed between the primary counselor or the program director and the patient in an effort to allow the patient to remain in treatment on condition that the patient adheres to service rules.

(o) "Treatment team" means a team established to evaluate the progress of a patient and consisting of at least the primary counselor, the service staff nurse who administers doses and the program director.

(4) REQUIRED PERSONNEL. (a) A narcotic treatment service for opiate addiction shall designate a physician licensed under ch. 448, Stats., as its medical director. The physician shall be readily accessible and able to respond in person in a reasonable period of time, not to exceed forty-five minutes.

(b) The service shall have a registered nurse on staff to supervise the dosing process and perform other functions delegated by the physician.

(c) The service may employ nursing assistants and related medical ancillary personnel to perform functions permitted under state medical and nursing practice statutes and administrative rules.

(d) The service shall employ certified substance abuse counselors or registered alcohol and drug counselors 1 who are under the supervision of a clinical supervisor on a ratio of at least one to 50 patients in the service or fraction thereof.

(e) The service shall have at least one clinical supervisor on staff to provide ongoing clinical supervision of the counseling staff or a person outside the agency who is certified by the Wisconsin certification board, inc., as a certified clinical supervisor and who by a written agreement will provide ongoing clinical supervision of counseling staff. The clinical supervisor shall provide supervision and performance evaluation of substance abuse counselors in the core functions identified in the certification standards of the Wisconsin certification board, inc., and shall exercise supervisory responsibility over substance abuse counselors in regard to at least the following: counselor development, counselor skill assessment and performance evaluation, staff management and administration, and professional responsibility.

(5) ADMISSION. (a) *Admission criteria.* For admission to a narcotic addiction treatment service for opiate addiction, a person shall meet all of the following criteria as determined by the service physician:

1. The person is physiologically and psychologically dependent upon a narcotic drug that may be a synthetic narcotic.

2. The person has been physiologically and psychologically dependent upon the narcotic drug not less than one year before admission.

3. In instances where the presenting drug history is inadequate to substantiate such a diagnosis, the material submitted by other health care professionals indicates a high degree of probability of such a diagnosis, based on further evaluation.

4. When the person receives health care services from outside the service, the person has provided names, addresses and written consents for release of information from each health care provider to allow the service to contact the providers, and agrees to update releases if changes occur.

(b) *Voluntary treatment.* Participation in narcotic addiction treatment shall be voluntary.

(c) *Explanation.* Service staff shall clearly and adequately explain to the person being admitted all relevant facts concerning the use of the narcotic drug used by the service.

(d) *Consent.* The service shall require a person being admitted to complete the most current version of FDA form 2635, "Consent to Narcotic Addiction Treatment."

Note: For copies of FDA Form 2635, Consent to Narcotic Addiction Treatment, a service may write to Commissioner, Food and Drug Administration, Division of Scientific Investigations, 5600 Fishers Lane, Rockville, MD 20857.

(e) *Examination.* For each applicant eligible for narcotic addiction treatment, the service shall arrange for completion of a comprehensive physical examination, clinically indicated laboratory work-up prescribed by the physician, psycho-social assessment, initial treatment plan and patient orientation during the admission process.

(f) *Initial dose.* If a person meets the admission criteria under par. (a), an initial dose of narcotic medication may be administered to the patient on the day of application.

(g) *Distance of service from residence.* A person shall receive treatment at a service located in the same county or at the nearest location to the person's residence, except that if a service is unavailable within a radius of 50 miles from the patient's residence, the patient may, in writing, request the state methadone authority to approve an exception. In no case may a patient be allowed to attend a service at a greater distance to obtain take-home doses.

(h) *Non-residents.* A self-pay person who is not a resident of Wisconsin may be accepted for treatment only after written notification to the Wisconsin state methadone authority. Permission shall be obtained before initial dosing.

(i) *Central registry.* 1. The service shall participate in a central registry, or an alternative acceptable to the state methadone authority, in order to prevent multiple enrollments in detoxification and narcotic addiction treatment services for opiate addiction. The central registry may include services and programs in bordering states.

2. The service shall make a disclosure to the central registry whenever any of the following occurs:

a. A person is accepted for treatment.

b. The person is disenrolled in the service.

3. The disclosure shall be limited to:

a. Patient-identifying information.

b. Dates of admission, transfer or discharge from treatment.

4. A disclosure shall be made with the patient's written consent that meets the requirements of 42 CFR Part 2, relating to alcohol and drug abuse patient records, except that the consent shall list the name and address of each central registry or acceptable alternative and each known detoxification or narcotic treatment service for opiate addiction to which a disclosure will be made.

(j) *Admissions protocol.* The service shall have a written admissions protocol that accomplishes all of the following:

1. Identifies the person on the basis of appropriate substantiated documents that contain the individual's name and address, date of birth, sex and race or ethnic origin as evidenced by a valid driver's license or other suitable documentation such as a passport.

2. Determines the person's current addiction, to the extent possible, the current degree of dependence on narcotics or opiates, or both, including route of administration, length of time of the patient's dependence, old and new needle marks, past treatment history and arrest record.

3. Determines the person's age. The patient shall verify that he or she is 18 years or older.

4. Identifies the substances being used. To the extent possible, service staff shall obtain information on all substances used, route of administration, length of time used and amount and frequency of use.

5. Obtains information about past treatment. To the extent possible, service staff shall obtain information on a person's treatment history, use of secondary substances while in the treatment, dates and length of time in treatment and reasons for discharge.

6. Obtains personal information about the person. Personal information includes history and current status regarding employment, education, legal status, military service, family and psychiatric and medical information.

7. Identifies the person's reasons for seeking treatment. Reasons shall include why the person chose the service and whether the person fully understands the treatment options and the nature and requirements of narcotic addiction treatment are fully understood.

8. Completes an initial drug screening or analysis of the person's urine to detect use of opiates, methadone, amphetamines, benzodiazepines, cocaine or barbiturates. The analysis shall show positive for narcotics, or an adequate explanation for negative results shall be provided and noted in the applicant's record. The primary counselor shall enter into the patient's case record the counselor's name, the content of a patient's initial assessment and the initial treatment plan. The primary counselor shall make these entries immediately after the patient is stabilized on a dose or within 4 weeks of admission, whichever is sooner.

9. If the service is at capacity, immediately advises the applicant of the existence of a waiting list and providing that person with a referral to another treatment service that can serve the person's treatment needs.

10. Refers a person who also has a physical health or mental health problem that cannot be treated within the service to an appropriate agency for appropriate treatment.

11. Obtains the person's written consent for the service to secure records from other agencies that may assist the service with treatment planning.

12. Arranges for hospital detoxification for patients seriously addicted to alcohol or sedatives or to anxiolytics before initiating outpatient treatment.

(k) *Priority admissions.* A service shall offer priority admission either through immediate admission or priority placement on a waiting list in the following order:

1. Pregnant women.

2. Persons with serious medical or psychiatric problems.

3. Persons identified by the service through screening as having an infectious or communicable disease, including screening for risk behaviors related to human immunodeficiency virus infection, sexually transmitted diseases and tuberculosis.

(L) *Appropriate and uncoerced treatment.* Service staff shall determine through a screening process that narcotic addiction treatment is the most appropriate treatment modality for the applicant and that treatment is not coerced.

(m) *Correctional supervision notification.* A service shall require a person who is under correctional supervision to provide written information releases that are necessary for the service to notify and communicate with the patient's probation and parole officer and any other correctional authority regarding the patient's participation in the service.

(6) ORIENTATION OF NEW PATIENTS. A service shall provide new patients with an orientation to the service that includes all of the following:

(a) A description of treatment policies and procedures.

(b) A description of patient rights and responsibilities.

(c) Provision of a copy of a patient handbook that covers treatment policies and procedures, and patient rights and responsibilities. The service shall require a new patient to acknowledge, in writing, receipt of the handbook.

(7) RESEARCH AND HUMAN RIGHTS COMMITTEE. A narcotic treatment service conducting or permitting research involving human subjects shall establish a research and human rights committee in accordance with s. 51.61 (4), Stats., and 45 CFR Part 46.

(8) RESEARCH. (a) All proposed research involving patients shall meet the requirements of s. 51.61 (1) (j), Stats., 45 CFR Part 46 and this subsection.

(b) No patient may be subjected to any experimental diagnostic or treatment technique or to any other experimental intervention unless the patient gives written informed consent and the research and human rights committee established under s. 51.61 (4), Stats., has determined that adequate provisions are made to do all of the following:

1. Protect the privacy of the patient.

2. Protect the confidentiality of treatment records in accordance with s. 51.30, Stats., and ch. HFS 92.

3. Ensure that no patient may be approached to participate in the research unless the patient's participation is approved by the person responsible for the patient's treatment plan.

(9) MEDICAL SERVICES. (a) A service may not provide any medical services not directly related to narcotic treatment. If a patient has medical service needs that are not directly related to narcotic treatment, the service shall refer the patient for appropriate health care.

(b) The medical director of a service is responsible for all of the following:

1. Administering all medical services provided by the service.

2. Ensuring that the service complies with all federal, state, and local statutes, ordinances and regulations regarding medical treatment of narcotic addiction.

3. Ensuring that evidence of current physiological or psychological dependence, length of history of addiction and exceptions as granted by the state methadone authority to criteria for admission are documented in the patient's case record before the initial dose is administered.

4. Ensuring that a medical evaluation including a medical history and a physical examination have been completed for a patient before the initial dose is administered.

5. Ensuring that appropriate laboratory studies have been performed and reviewed.

6. Signing or countersigning all medical orders as required by federal or state law, including all of the following:

a. Initial medical orders and all subsequent medical order changes.

b. Approval of all take-home medications.

c. Approval of all changes in frequency of take-home medication.

d. Prescriptions for additional take-home medication for an emergency situation.

7. Reviewing and countersigning each treatment plan 4 times annually.

8. Ensuring that justification is recorded in the patient's case record for reducing the frequency of service visits for observed drug ingesting and providing additional take-home medication under exceptional circumstances or when there is physical disability, as well as when any medication is prescribed for physical health or psychiatric problems.

9. The amount of narcotic drug administered or dispensed, and for recording, signing and dating each change in the dosage schedule in a patient's case record.

(c) A service physician is responsible for all of the following:

1. Determining the amount of the narcotic drug to be administered or dispensed and recording, signing and dating each change in a patient's dosage schedule in the patient's case record.

2. Ensuring that written justification is included in a patient's case record for a daily dose greater than 100 milligrams.

3. Approving, by signature and date, any request for an exception to the requirements under sub. (11) relating to take-home medications.

4. Detoxification of a patient from narcotic drugs and administering the narcotic drug or authorizing an agent to administer it under physician supervision and physician orders in a manner that prevents the onset of withdrawal symptoms.

5. Making a clinical judgment that treatment is medically justified for a person who has resided in a penal or chronic care institution for one month or longer, under the following conditions:

a. The person is admitted to treatment within 14 days before release or discharge or within 6 months after release without documented evidence to support findings of physiological dependence.

b. The person would be eligible for admission if he or she were not incarcerated or institutionalized before eligibility was established.

c. The admitting service physician or service personnel supervised by the service physician records in the new patient's case record evidence of the person's prior residence in a penal or chronic care institution and evidence of all other findings of addiction.

d. The service physician signs and dates the recordings under subd. 5. c. before the initial dose is administered to the patient or within 48 hours after administration of the initial dose to the patient.

(d) A patient's history and physical examination shall support a judgment on the part of the service physician that the patient is a suitable candidate for narcotic addiction treatment.

(e) A service shall provide narcotic addiction treatment to a patient for a maximum of 2 years from the date of the person's admission to the service, unless clear justification for longer service provision is documented in the treatment plan and progress notes. Clear justification for longer service shall include documentation of all of the following:

1. The patient continues to benefit from the treatment.

2. The risk of relapse is no longer present.

3. The patient exhibits no side effects from the treatment.

4. Continued treatment is medically necessary in the professional judgment of the service physician.

(10) DOSAGE. (a) Because methadone and other FDA-approved narcotics are medications, the dose determination for a patient is a matter of clinical judgment by a physician in consultation with the patient and appropriate staff of the service.

(b) The service physician who has examined a patient shall determine, on the basis of clinical judgment, the appropriate narcotic dose for the patient.

(c) Any dose adjustment, either up or down, to sanction the patient, to reinforce the patient's behavior or for purposes of treatment contracting, is prohibited, except as provided in sub. (h).

(d) The service shall delay administration of methadone to an objectively intoxicated patient until diminution of intoxication symptoms can be documented, or the patient shall be readmitted for observation for withdrawal symptoms while augmenting the patient's daily dose in a controlled, observable fashion.

(e) The narcotic dose that a service provides to a patient shall be sufficient to produce the desired response in the patient for the desired duration of time.

(f) A patient's initial dose shall be based on the service physician's evaluation of the history and present condition of the patient. The evaluation shall include knowledge of local conditions, such as the relative purity of available street drugs. The initial dose may not exceed 30 milligrams except that the total dose for the first day may not exceed 40 milligrams.

(g) A service shall incorporate withdrawal planning as a goal in a patient's treatment plan, and shall begin to address it once the patient is stabilized. A service physician shall determine the rate of withdrawal to prevent relapse or withdrawal symptoms.

(h) 1. A service physician may order the withdrawal of a patient from medication for administrative reasons, such as extreme antisocial behavior or noncompliance with minimal service standards.

2. The process of withdrawal from medication for administrative reasons shall be conducted in a humane manner as determined by the service physician, and referral shall be made to other treatment services.

(11) TAKE-HOME MEDICATION PRACTICES. (a) *Granting take-home privileges.* During treatment, a patient may benefit from less frequent required visits for dosing. This shall be based on an assessment by the treatment staff. Time in treatment is not the sole consideration for granting take-home privileges. After consideration of treatment progress, the service physician shall determine if take-home doses are appropriate or if approval to take home doses should be rescinded. Federal requirements that shall be adhered to by the state methadone authority and the service are as follows:

1. Take-home doses are not allowed during the first 90 days of treatment. Patients shall be expected to attend the service daily, except Sundays, during the initial 90-day period with no exceptions granted.

2. Take-home doses may not be granted if the patient continues to use illicit drugs and if the primary counselor and the treatment team determine that the patient is not making progress in treatment and has continued drug use or legal problems.

3. Take-home doses shall only be provided when the patient is clearly adhering to the requirements of the service. The patient shall be expected to show responsibility for security and handling of take-home doses.

4. Service staff shall go over the requirements for take-home privileges with a patient before the take-home practice for self-dosing is implemented. The service staff shall require the patient to provide written acknowledgment that all the rules for self-dosing have been provided and understood at the time the review occurs.

5. Service staff may not use the level of the daily dose to determine whether a patient receives take-home medication.

(b) *Treatment team recommendation.* A treatment team of appropriate staff in consultation with a patient shall collect and evaluate the necessary information regarding a decision about take-home medication for the patient and make the recommendation to grant take-home privileges to the service physician.

(c) *Service physician review.* The rationale for approving, denying or rescinding take-home privileges shall be recorded in the patient's case record and the documentation shall be reviewed, signed and dated by the service physician.

(d) *Service physician determination*. The service physician shall consider and attest to all of the following in determining whether, in the service physician's reasonable clinical judgment, a patient is responsible in handling narcotic drugs and has made substantial progress in rehabilitation:

1. The patient is not abusing substances, including alcohol.

2. The patient keeps scheduled service appointments.

3. The patient exhibits no serious behavioral problems at the service.

4. The patient is not involved in criminal activity, such as drug dealing and selling take-home doses.

5. The patient has a stable home environment and social relationships.

6. The patient has met the following criteria for length of time in treatment starting from the date of admission:

a. Three months in treatment before being allowed to take home doses for 2 days.

b. Two years in treatment before being allowed to take home doses for 3 days.

c. Three years in treatment before being allowed to take home doses for 6 days.

7. The patient provides assurance that take-home medication will be safely stored in a locked metal box within the home.

8. The rehabilitative benefit to the patient in decreasing the frequency of service attendance outweighs the potential risks of diversion.

(e) *Time in treatment criteria.* The time in treatment criteria under par. (d) 6. shall be the minimum time before take-home medications will be considered unless there are exceptional circumstances and the service applies for and receives approval from the FDA and the state methadone authority for a particular patient for a longer period of time.

(f) *Individual consideration of request.* A request for take-home privileges shall be considered on an individual basis. No request for take-home privileges may be granted automatically to any patient.

(g) *Additional criteria for 6-day take-homes*. When a patient is considered for 6-day take-homes, the patient shall meet the following additional criteria:

1. The patient is employed, attends school, is a homemaker or is disabled.

2. The patient is not known to have used or abused substances, including alcohol, in the previous year.

3. The patient is not known to have engaged in criminal activity in the previous year.

(h) *Observation requirement.* A patient receiving a daily dose of a narcotic medication above 100 milligrams is required to be under observation while ingesting the drug at least 6 days per week, irrespective of the length of time in treatment, unless the service has received prior approval from the designated federal agency, with concurrence by the state methadone authority, to waive this requirement.

(i) *Denial or rescinding of approval.* A service shall deny or rescind approval for take-home privileges for any of the following reasons:

1. Signs or symptoms of withdrawal.

2. Continued illicit substance use.

3. The absence of laboratory evidence of FDA-approved narcotic treatment in test samples, including serum levels.

4. Potential complications from concurrent disorders.

5. Ongoing or renewed criminal behavior.

6. An unstable home environment.

(j) *Review.* 1. The service physician shall review the status of every patient provided with take-home medication at least every 90 days and more frequently if clinically indicated.

2. The service treatment team shall review the merits and detriments of continuing a patient's take-home privilege and shall make appropriate recommendations to the service physician as part of the service physician's 90-day review.

3. Service staff shall use biochemical monitoring to ensure that a patient with take-home privileges is not using illicit substances and is consuming the FDA-approved narcotic provided.

4. Service staff may not recommend denial or rescinding of a patient's take-home privilege to punish the patient for an action not related to meeting requirements for take-home privileges.

(k) *Reduction of take-home privileges or requirement of more frequent visits to the service.* 1. A service may reduce a patient's take-home privileges or may require more frequent visits to the service if the patient inexcusably misses a scheduled appointment with the service, including an appointment for dosing, counseling, a medical review or a psychosocial review or for an annual physical or an evaluation.

2. A service may reduce a patient's take-home privileges or may require more frequent visits to the service if the patient shows positive results in drug test analysis for morphine-like substances or substances of abuse or if the patient tests negative for the narcotic drug administered or dispensed by the service.

(L) *Reinstatement.* A service shall not reinstate take-home privileges that have been revoked until the patient has had at least 3 consecutive months of tests or analyses that are neither positive for morphine-like substances or substances of abuse or negative for the narcotic drug administered or dispensed by the service, and the service physician determines that the patient is responsible in handling narcotic drugs.

(m) *Clinical probation.* 1. A patient receiving a 6-day supply of take-home medication who has a test or analysis that is confirmed to be positive for a substance of abuse or negative for the narcotic drug dispensed by the service shall be placed on clinical probation for 3 months.

2. A patient on 3-month clinical probation who has a test or analysis that is confirmed to be positive for a substance of abuse or negative for the narcotic drug administered or dispensed by the service shall be required to attend the service at least twice weekly for observation of the ingestion of medication, and may receive no more than a 3-day take-home supply of medication.

(n) *Employment-related exception to 6-day supply.* A patient who is employed and working on Saturdays may apply for an exception to the dosing requirements if dosing schedules of the service conflict with working hours of the patient. A service may give the patient an additional take-home dose after verification of work hours through pay slips or other reliable means, and following approval for the exception from the state methadone authority.

(12) EXCEPTIONS TO TAKE-HOME REQUIREMENTS. (a) A service may grant an exception to certain take-home requirements for a particular patient if, in the reasonable clinical judgment of the program physician, any of the following conditions is met:

1. The patient has a physical disability that interferes with his or her ability to conform to the applicable mandatory schedule. The patient may be permitted a temporarily or permanently reduced schedule provided that she or he is found under par. (c) to be responsible in handling narcotic drugs.

2. The patient, because of an exceptional circumstance such as illness, personal or family crisis, travel or other hardship, is unable to conform to the applicable mandatory schedule. The patient may be permitted a temporarily reduced schedule, provided that she or he is found under par. (c) to be responsible in handling narcotic drugs.

(b) The program physician or program personnel supervised by the program physician shall record the rationale for an exception to an applicable mandatory schedule in the patient's case record. If program personnel record the rationale, the physician shall review, countersign and date the rationale in the patient's record. A patient may not be given more than a 14-day supply of narcotic drugs at one time.

(c) The service physician's judgment that a patient is responsible in handling narcotic drugs shall be supported by information in the patient's case file that the patient meets all of the following criteria:

1. Absence of recent abuse of narcotic or non-narcotic drugs including alcohol.

2. Regularity of service attendance.

3. Absence of serious behavior problems in the service.

4. Absence of known recent criminal activity such as drug dealing.

5. Stability of the patient's home environment and social relationships.

6. Length of time in maintenance treatment.

7. Assurance that take-home medication can be safely stored within the patient's home.

8. The rehabilitative benefit to the patient derived from decreasing the frequency of attendance outweighs the potential risks of diversion.

(d) 1. Any exception to the take-home requirements exceeding 2 times the amount in that phase is subject to approval of the designated federal agency and the state methadone authority. The following is the amount of additional take-home doses needing approval: Phase 1 = 2 additional (excluding Sunday); phase 2 = 4 additional; phase 3 = 6 additional; phase 4 = 12 take home doses required for approval.

2. Service staff on receipt of notices of approval or denial of a request for an extension from the state methadone authority and the designated federal agency shall place the notices in the patient's case record.

(e) Service staff shall review an exception when the conditions of the request change or at the time of review of the treatment plan, whichever occurs first.

(f) An exception shall remain in effect only as long as the conditions establishing the exception remain in effect.

(13) TESTING AND ANALYSIS FOR DRUGS. (a) *Use*. 1. A service shall use drug tests and analyses to determine the presence in a patient of opiates, methadone, amphetamines, cocaine or barbiturates. If any other drug has been determined by a service or the state methadone authority to be abused in that service's locality, a specimen shall also be analyzed for that drug. Any laboratory that performs the testing shall comply with 42 CFR Part 493.

2. A service shall use the results of a drug test or analysis on a patient as a guide to review and modify treatment approaches and not as the sole criterion to discharge the patient from treatment.

3. A service's policies and procedures shall integrate testing and analysis into treatment planning and clinical practice.

(b) *Drawing blood for testing*. A service shall determine a patient's drug levels in plasma or serum at the time the person is admitted to the service to determine a baseline. The determinations shall also be made at 3 months, 6 months and annually subsequently. If a patient requests and receives doses above 100 milligrams, serum levels shall be drawn to evaluate peak and trough determinations after the patient's dose is stabilized.

(c) *Obtaining urine specimens*. A service shall obtain urine specimens for testing from a patient in a clinical atmosphere that respects the patient's confidentiality, as follows:

1. A urine specimen shall be collected upon each patient's service visit and specimens shall be tested on a random basis.

2. The patient shall be informed about how test specimens are collected and the responsibility of the patient to provide a specimen when asked.

3. The bathroom used for collection shall be clean and always supplied with soap and toilet articles.

4. Specimens shall be collected in a manner that minimizes the possibility of falsification.

5. When service staff must directly observe the collection of a urine sample, this task shall be done with respect for patient privacy.

(d) *Response to positive test results.* 1. Service staff shall discuss positive test results with the patient within one week after receipt of results and shall document them in the patient's case record with the patient's response noted.

2. The service shall provide counseling, casework, medical review and other interventions when continued use of substances is identified. Punishment is not appropriate.

3. When there is a positive test result, service staff shall allow sufficient time before re-testing to prevent a second positive test result from the same substance use.

4. Service staff confronted with a patient's denial of substance use shall consider the possibility of a false positive test.

5. Service staff shall review a patient's dosage and shall counsel the patient when test reports are positive for morphine-like substances and negative for the FDA-approved narcotic treatment.

(e) *Monitoring of test reports.* A service shall monitor test reports to do all of the following:

1. Ensure compliance with this section and with federal regulations.

2. Discover trends in substance use that may require a redirection of clinical resources.

3. Ensure that staff appropriately address with the patient a positive test report within one week after the report is received and that the report and the patient's response is documented in the patient's case record.

(f) *Frequency of drug screens.* 1. The frequency that a service shall require drug screening shall be clinically appropriate for each patient and allow for a rapid response to the possibility of relapse.

2. A service shall arrange for drug screens with sufficient frequency so that they can be used to assist in making informed decisions about take-home privileges.

(14) TREATMENT DURATION AND RETENTION. (a) Patient retention shall be a major objective of treatment. The service shall do all of the following to retain patients for the planned course of treatment:

1. Make the service physically accessible.

2. Render treatment in a way that is least disruptive to the patient's travel, work, educational activities, ability to use supportive services and family life.

3. Determine hours based on patient needs.

4. Provide affordable treatment to all needing it.

5. Ensure that a patient has ready access to staff, particularly to the patient's primary counselor.

6. Ensure that staff are adequately trained and are sensitive to gender-specific and culture-specific issues.

7. Provide services that incorporate good practice standards for substance abuse treatment.

8. Ensure that patients receive adequate doses of narcotic medication based on their individual needs.

9. Ensure that the attitude of staff is accepting of narcotic addiction treatment.

10. Ensure that patients understand that they are responsible for complying with all aspects of their treatment, including participating in counseling sessions.

(b) Since treatment duration and retention are directly correlated to rehabilitation success, a service shall make a concerted effort to retain patients within the first year following admission. Evidence of this concerted effort shall include written documentation of all of the following:

1. The patient continues to benefit from the treatment.

2. The risk of relapse is discontinued.

3. The patient exhibits no side effects from the treatment.

4. Continued treatment is medically necessary in the professional judgement of the service physician.

(c) A service shall refer an individual discharged from the service to a more suitable treatment modality when further treatment is required or is requested by that person and cannot be provided by the service.

(d) For services needed by a patient but not provided by the service, the service shall refer the individual to an appropriate service provider.

(15) MULTIPLE SUBSTANCE USE AND DUAL DIAGNOSIS TREATMENT.(a) *Assessment.* A service shall assess an applicant for admission during the admission process and a patient, as appropriate, to distinguish substance use, abuse and dependence, and determine patterns of other substance use and self-reported etiologies, including non-prescription, non-therapeutic and prescribed therapeutic use and mental health problems.

(b) *Multiple substance use patients*. 1. A service shall provide a variety of services that support cessation by a patient of alcohol and prescription and non-prescription substance abuse as the desired goal.

2. Service objectives shall indicate that abstinence by a patient from alcohol and prescription and non-prescription substance abuse should extend for increasing periods, progress toward long-term abstinence and be associated with improved life functioning and well-being.

3. Service staff shall instruct multiple substance use patients about their vulnerabilities to cross-tolerance, drug-to-drug interaction and potentiation and the risk of dependency substitution associated with self-medication.

(c) *Dually-diagnosed patients.* 1. A service shall have the ability to provide concurrent treatment for a patient diagnosed with both a mental health disorder and a substance use disorder. The service shall arrange for coordination of treatment options and for provision of a continuum of care across the boundaries of physical sites, services and outside treatment referral sources.

2. When a dual diagnosis exists, a service shall develop with the patient a treatment plan that integrates measures for treating all alcohol, drug and mental health problems. For the treatment of a dually-diagnosed patient, the service shall arrange for a mental health professional to help develop the treatment plan and provide ongoing treatment services. The mental health professional shall be available either as an employe of the service or through a written agreement.

(16) PREGNANCY. (a) A service that provides narcotic addiction treatment to pregnant women shall provide that treatment within a comprehensive treatment service that addresses medical, prenatal, obstetrical, psychosocial and addiction issues.

(b) A diagnosis of opioid addiction and need of the patient to avoid use of narcotic antagonists shall be based on the same factors, such as medical and substance abuse history, psychosocial history, physical examination, test toxicology and signs and symptoms of withdrawal, that are used in diagnosing opiate addiction in non-pregnant opioid-dependent women. In this paragraph, "narcotic antagonist" means a drug primarily used to counter narcotic-induced respiratory depression.

(c) A pregnant women seeking narcotic addiction treatment shall be referred to a perinatal specialist or obstetrician as soon as possible after initiating narcotic addiction treatment with follow up contact, to coordinate care of the woman's prenatal health status, evaluate fetal growth and document physiologic dependence.

(d) 1. When withdrawal from narcotic medication is the selected treatment option, withdrawal shall be conducted under the supervision of a service physician experienced in perinatal addiction, ideally in a perinatal unit equipped with fetal monitoring equipment.

2. Withdrawal shall not be initiated before the 14th week of pregnancy or after the 32nd week of pregnancy.

(e) Pregnant women shall be monitored and their dosages individualized, as needed.

(f) A service shall not change the methadone dose that a pregnant woman was receiving before her pregnancy unless necessary to avoid withdrawal.

(g) A service shall increase the methadone dose for a patient, if needed, during the later stages of the patient's pregnancy to maintain the same plasma level and avoid withdrawal.

(h) A service shall arrange for appropriate assistance for pregnant patients, including education and parent support groups, to improve mother-infant interaction after birth and to lessen the behavioral consequences of poor mother-infant bonding.

(17) COMMUNICABLE DISEASE. (a) A narcotic treatment service for opiate addiction shall screen patients immediately following admission and annually thereafter for tuberculosis (TB). Tuberculosis treatment may be provided by referral to an appropriate public health agency or community medical service.

(b) A service shall screen prospective new staff for TB, and shall annually test all service staff for TB.

(c) A service shall screen all patients at admission and annually thereafter for viral hepatitis and sexually transmitted diseases (STDs) and shall ensure that any necessary medical follow-up occurs, either on-site or through referral to community medical services.

(d) A service shall ensure that all service staff have been immunized against hepatitis B. Documentation of refusal to be immunized shall be entered in the staff member's case record.

(18) FACILITY. A service shall provide a setting that is conducive to rehabilitation of the patients and that meets all of the following requirements:

(a) The waiting area for dosing shall be clean.

(b) Waiting areas, dosing stations and all other areas for patients shall be provided with adequate ventilation and lighting.

(c) Dosing stations and adjacent areas shall be kept sanitary and ensure privacy and confidentiality.

(d) Patient counseling rooms, physical examination rooms and other rooms or areas in the facility that are used to meet with patients shall have adequate sound proofing so that normal conversations will be confidential.

(e) Adequate security shall be provided inside and outside the facility for the safety of the patients and to prevent loitering and illegal activities.

(f) Separate toilet facilities shall be provided for patient and staff use.

(g) The facility and areas within the facility shall be accessible to persons with physical disabilities.

(h) The physical environment within the facility shall be conducive to promoting improved functioning and a drug free lifestyle.

(19) DIVERSION CONTROL. (a) Each staff member of the narcotic treatment service for opiate addiction is responsible for being alert to potential diversion of narcotic medication by patients and staff.

(b) Service staff shall take all of the following measures to minimize diversion:

1. Doses of narcotic medication shall be dispensed only in liquid form.

2. Bottles of narcotic medication shall be labeled with the patient's name, the dose, the source service, the prescribing physician and the date by which the dose is to be consumed.

3. The service shall require a patient to return all empty take-home bottles on the patient's next day of service attendance following take-home dosing. Service staff shall examine the bottles to ensure that the bottles are received from the appropriate patient and in an intact state.

4. The service shall discontinue take-home medications for patients who fail to return empty take-home bottles in the prescribed manner.

(c) If a service receives reliable information that a patient is diverting narcotic medication, the patient's primary counselor shall immediately discuss the problem with the patient.

(d) Based on information provided by the patient or continuing reports of diversion, a service may revoke take-home privileges of the patient.

(e) The state methadone authority may, based on reports of diversion, revoke take-home privileges, exceptions or exemptions granted to or by the service for all patients.

(f) The state methadone authority may revoke the authority of a narcotic treatment service for opiate addiction to grant take-home privileges when the service cannot demonstrate that all requirements have been met in granting take-home privileges.

(g) A narcotic treatment service for opiate addiction shall have a written policy to discourage the congregation of patients at a location inside or outside the service facility for non-programmatic reasons, and shall post that policy in the facility.

(20) SERVICE APPROVAL. (a) *Approval of primary service.* An applicant for approval to operate a narcotic treatment service for opiate addiction in Wisconsin with the intent of administering or dispensing a narcotic drug to narcotic addicts for maintenance or detoxification treatment shall submit all of the following to the state methadone authority:

1. Copies of all completed designated federal agency applications.

2. A copy of the request for registration with the U.S. drug enforcement administration for the use of narcotic medications in the treatment of opiate addiction.

3. A narrative description of the treatment services that will be provided in addition to chemotherapy.

4. Documentation of the need for the service.

5. Criteria for admitting a patient.

6. A copy of the policy and procedures manual for the service, detailing the operation of the service as follows:

a. A description of the intake process.

b. A description of the treatment process.

c. A description of the expectations the service has for a patient.

d. Descriptions of any service privileges or sanctions.

e. A description of the service's use of testing or analysis to detect substances and the purposes for which the results of testing or analysis are used as well as the frequency of use.

7. Documentation that there are adequate physical facilities to provide all necessary services.

8. a. Documentation that the service will have ready access to a comprehensive range of medical and rehabilitative services that will be available if needed.

b. The name, address, and a description of each hospital, institution, clinical laboratory or other facility available to provide the necessary services.

9. A list of persons working in the service who are licensed to administer or dispense narcotic drugs even if they are not responsible for administering or dispensing narcotic drugs.

(b) *Approval of service sites*. Only service sites approved by the FDA, the U.S. drug enforcement administration and the state methadone authority may be used for treating narcotic addicts with a narcotic drug.

(c) *Approval of medication units*. 1. To operate a medication unit, a service shall apply to the department for approval to operate the medication unit. A separate approval is required for each medication unit to be operated by the service. A medication unit is established to facilitate the needs of patients who are stabilized on an optimal dosage level. The department shall approve a medication unit before it may begin operation.

2. Approval of a medication unit shall take into consideration the distribution of patients and other medication units in a geographic area.

3. If a service has its approval revoked, the approval of each medication unit operated by the service is automatically revoked. Revocation of the approval of a medication unit does not automatically affect the approval of the primary service.

Note: To apply for approval to operate a medication unit, contact the State Methadone Authority in the Bureau of Substance Abuse Services at P.O. Box 7851, Madison, WI 53707-7851. Approvals of the FDA and the U.S. Drug Enforcement Administration to operate a medication unit are also required. The State Methadone Authority will facilitate the application consideration by the FDA and the U.S. Drug Enforcement Administration.

(21) ASSENT TO REGULATION. (a) A person who sponsors a narcotic treatment service for opiate addiction and any personnel responsible for a particular service shall agree in writing to adhere to all applicable requirements of this chapter and 21 CFR Part 291 and 42 CFR Part 2.

(b) The service sponsor is responsible for all service staff and for all other service providers who work in the service at the primary facility or at other facilities or medication units.

(c) The service sponsor shall agree in writing to inform all service staff and all contracted service providers of the provisions of all pertinent state rules and federal regulations and shall monitor their activities to ensure that they comply with those rules and regulations.

(d) The service shall notify the designated federal agency and state methadone authority within 3 weeks after replacement of the service sponsor or medical director.

(22) DEATH REPORTING. A narcotic treatment service for opiate addiction shall report the death of any of its patients to the state methadone authority within one week after learning of the patient's death.

APPENDIX A

PREVENTIVE INTERVENTIONS CLASSIFICATION SYSTEM

Category	Description	Examples	Cost Considerations
Universal Measures	Interventions that can be advocated confidently for the general public and which, in many cases, can be applied without professional advice or assistance.	Adequate diet, dental hygiene, use of seat belts in automobiles, lead awareness and removal, smoking cessation, and many forms of immunization.	By serving everyone, there may be costs that are incurred for families and individuals who do not need help. Cost of intervention per family or individual can be low because the intervention is less intensive.
Selective Measures	Subgroups who share common general risk factors, which are distinguished by age, sex, occupation, or other obvious characteristic.	Avoidance of alcohol and many drugs by pregnant women, parenting skill improvement for parents who were raised in abusive households.	Costs are focused on families or persons in subgroups of the general population who may need extra help. Costs are increased by targeting high-risk populations. Intervention may be more expensive because of the need to address the specific risks of participants.
Indicated Measures	Interventions that are advisable only for persons who, on examination or screening, are found to manifest a risk factor, condition, or abnormality that identifies them, individually, as being at sufficiently high risk to require the preventive intervention. The majority of these interventions have been called secondary under the classical scheme.	Control of hypertension, provide parents and families with sustained therapeutic counseling, therapeutically focused parent or family skills training, provide extensive opportunity for families to integrate new behavior patterns and skills.	Cost is targeted to those most in need. Cost per individual or family is high because the intervention requires sustained, intensive efforts.

APPENDIX B

QUALIFICATIONS OF STAFF WHO PROVIDE MENTAL HEALTH TREATMENT SERVICES TO DUALLY DIAGNOSED PATIENTS

The following are the qualifications staff must have who provide mental health treatment services to dually diagnosed patients:

1. A physician shall be licensed under ch. 448, Stats., to practice medicine and surgery and have completed 3 years of residency training in psychiatry or child psychiatry in a program approved by the accreditation council for graduate medical education and be either board-certified or eligible for certification by the American board of psychiatry and neurology.

2. A psychologist shall be licensed under ch. 455, Stats., and be listed or meet the requirements for being listed with the national register of health services providers in psychology or have a minimum of one year of supervised post-doctoral clinical experience related directly to the assessment and treatment of persons with mental disorders.

3. A psychology resident shall have a doctoral degree in psychology meeting the requirements of 455.04 (1) (c), Stats., and have successfully completed 1500 hours of supervised clinical experience as documented by the Wisconsin psychology examining board.

4. A psychiatric resident shall have a doctoral degree in medicine as a medical doctor or doctor of osteopathy and have successfully completed 1500 hours of supervised clinical experience as documented by the program director of a psychiatric residency program accredited by the accreditation council for graduate medical education.

5. A certified independent clinical social worker shall meet the qualifications established in ch. 457, Stats., and be certified by the examining board of social workers, marriage and family therapists and professional counselors.

6. A psychiatric nurse shall be licensed under ch. 441, Stats., as a registered nurse, have completed 3000 hours of supervised clinical experience and hold a master's degree in psychiatric mental health nursing from a graduate school of nursing accredited by the national league for nursing.

7. A professional counselor or marriage and family therapist shall meet the qualifications required in ch. 457, Stats., and be certified by the examining board of social workers, marriage and family therapists and professional counselors.

8. A master's level clinician shall have a master's degree and coursework in areas directly related to providing mental health services, including clinical psychology, psychology, school or educational psychology, rehabilitation psychology, counseling and guidance or counseling psychology. A master's level mental health professional shall have 3,000 hours of supervised experience in clinical practice, which means a minimum of one hour per week of supervision during the 3,000 hour period by another mental health professional qualified under s. HFS 34.21 (3) (b) 1. to 9., gained after the person being supervised, has received a master's degree, or is listed in the national registry of health care providers in clinical social work, the national association of social workers register of clinical social workers, the national academy of certified mental health counselors or the national register of health service providers in psychology.

APPENDIX C

REGIONAL OFFICES OF THE DIVISION OF SUPPORTIVE LIVING

The Department of Health and Family Services certifies substance abuse services (programs) through Division of Supportive Living regional offices. Below are addresses and phone numbers of the regional offices and the counties they serve.

	COUNTIES
NORTHEASTERN OFFICE (Green Bay) 200 N. Jefferson Suite 411 Green Bay, WI 54301 (920) 448-5312	Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, Winnebago Tribes: Menominee, Oneida, Stockbridge-Munsee
SOUTHEASTERN OFFICE (Milwaukee) 141 NW Barstow Waukesha, WI 53188 (414) 521-5100	Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha
SOUTHERN OFFICE (Madison) 3601 Memorial Drive Madison, WI 53704 (608) 243-2400	Adams, Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Juneau, LaFayette, Richland, Rock, Sauk
WESTERN OFFICE (Eau Claire) 610 Gibson Street Eau Claire, WI 54701-3687 (715) 836-2174	Barron, Buffalo, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Jackson, LaCrosse, Monroe, Pepin, Pierce, Polk, Rusk, St. Croix, Trempealeau, Vernon, Washburn Tribes: Ho Chunk, St. Croix
NORTHERN OFFICE (Rhinelander) P.O. Box 697 Rhinelander, WI 54501 (715) 365-2500	Ashland, Bayfield, Florence, Forest, Iron, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Sawyer, Taylor, Vilas, Wood Tribes: Bad River, Lac Courte Oreilles, Lac du Flambeau, Red Cliff, Sokaogon, Forest Co. Potawatomi

The repeals and rules included in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.22 (2), Stats.

WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

Dated:

By:_____
Joseph Leean
Secretary

SEAL: